OAH 84-0900-30877

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF HEALTH

In the Matter of Park Health and Rehabilitation (IIDR)

RECOMMENDED DECISION

This matter came before Chief Administrative Law Judge Tammy L. Pust for an independent informal dispute resolution meeting (IIDR) on January 30, 2014. The IIDR concluded on that date.

Christine R. Campbell, Registered Nurse and Nurse Evaluator, appeared on behalf of the Minnesota Department of Health (Department). The following individuals also participated in the IIDR on behalf of the Department: Mary Cahill, Planner Principal with the Department's Division of Compliance Monitoring; Stephanie Richard, Surveyor with the Department's Office of Health Facility Complaints; and James Dostal, Regional Ombudsman, Office of Ombudsman for Long-Term Care, Minnesota Board on Aging.

Rebecca K. Coffin, Voigt, Rodè & Boxeth, LLC, appeared on behalf of Park Health and Rehabilitation (PH&R or Facility). The following persons also attended the IIDR and made comments on behalf of the Facility: Kristie Johnsrud, PH&R Administrator; Vanessa Love, PH&R Director of Nursing; and Lindsey Miller, PH&R Social Services staff.

Based on the submissions of the parties at the IIDR, the Administrative Law Judge makes the following:

FINDINGS OF FACT

1. The Department's Office of Health Facility Complaints (OHFC) is charged with implementing federal and state laws and regulations related to long-term care facilities in the state of Minnesota. On or about March 19, 2013, the Department issued updated Informational Bulletin 94-1; NH-10; CBC-4, titled "Nursing Home Discharge/Transfer Notices." The Informational Bulletin provided regulated facilities with an updated sample notice and a current ombudsman directory for facilities' use in situations involving involuntary discharge or transfer of residents.[1]

2. The Informational Bulletin included the following directives:

[1] Exhibit (Ex.) G-2.

a. All involuntary discharge notices must include the following information: reason for discharge; effective date of discharge; location of discharge; statement of appeal rights; contact information for the state long-term care ombudsman; contact information for advocates for developmentally disabled individuals and for mentally ill individuals.

b. Involuntary discharge notices, originally issued in noncompliance with 42 C.F.R. § 483.12(a)(6), must provide "a new 30 day notice period" upon reissuance.[2]

c. Involuntary discharge notices should include the following address for filing appeals allowed pursuant to Minn. Stat. § 144A.135:

Department of Health
Attn: Appeals Coordinator
Office of Health Facility Complaints
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone (651) 201-4201 or (800) 369-7994
Fax: (651) 281-9796[3]

2. The Facility participates in the federal Medicare and Medicaid Programs, and is therefore a regulated facility in the state of Minnesota. The Facility has enacted various operational policies and procedures required of a regulated facility, including its Involuntary Discharge Procedure.[4]

3. This matter arises from the involuntary discharge from the Facility of the Resident, a 44-year-old male with a medical history of depression, obesity, substance abuse and hip dysplasia. [5]

4. Prior to the events related to this matter, the Resident resided at the Harbor Light Center (Harbor Lights), a homeless shelter located in Minneapolis, Minnesota.[6]

5. At all times relevant to this matter, the Resident was of a sufficient cognition level so as to be capable of managing self-cares, expressing his preferences regarding placement and treatment-related options, and understanding communications directed to him by Facility staff and others.[7]

[2] Ex. G-3.
[3] Ex. G-4.
[4] Ex. 33.
[5] Ex. 11.
[6] Ex. 2.
[7] Ex. 9; Testimony (Test.) of Vanessa Love.

6. The Resident was admitted to the Facility on January 5, 2013 following a hospitalization for hip arthroplasty surgery and for the purpose of regaining strength and medical stabilization in order to be fit for additional anticipated surgery.[8]

7. Following a second hospitalization and related surgical procedure, the Resident was readmitted to the Facility on March 9, 2013.[9] During this stay at the Facility, the Resident received occupational therapy, physical therapy and nursing services relative to care of his surgical incision, antibiotic therapy, pain management, and strength conditioning therapies.

8. During his stay at the Facility, the Resident was prescribed morphine sulfate, 30 mg tablets twice daily, by his treating physician for pain management.[10]

9. Within two days of his readmission, the Resident was involved in an incident in which he closed a bathroom door in another resident's face. He was directed by the nursing staff regarding the inappropriate nature of his behavior, and also directed to discontinue aggressive behaviors directed at the nursing staff or others.[11]

10. The Facility commenced active discharge planning for the Resident as early as March 19, 2013. At a care conference held on that date, the Facility's social worker informed the Resident that he might have to be discharged back to Harbor Lights if he was unable to gain admittance to a residential substance abuse program by the time of his discharge.[12]

11. Certain criteria had to be met by the time of his discharge in order for the Resident to enter a substance abuse treatment program, including: completion of a Rule 25 evaluation; cessation of all prescribed pain medications; and the availability of a placement slot, which generally required being on a waiting list for two to three weeks.[13]

12. The Resident was actively involved in his discharge planning. He informed the Facility that he preferred to be discharged to Minnesota Teen Challenge or the Beacon Program, made telephone calls to a few treatment programs to inquire about waiting lists, and arranged tours of two programs located in St. Peter, Minnesota.[14]

13. As of April 3, 2013, the Resident had met his physical therapy goals. As a result, the Facility discontinued his physical therapy services.[15] He still received nursing services related to his pain management prescription.

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[8] Ex. 3.
[9] Ex. 6.
[10] Ex. 12.
[11] Ex. 14.
[12] Test. of Lindsey Miller
[13] *Id.*
[14] *Id.*
[15] Ex. 4.

14. On April 4, 2013, the Resident was involved in a verbal altercation with his roommate at the Facility.[16]

15. On April 7, 2013, another resident reported to the Facility's nursing staff that the Resident had been drinking alcohol at the Facility and was "beligerant [sp], swearing and being rude."[17] Though the nursing staff documented an intent to report this information to Facility management, the Director of Nursing was not made aware of this report.[18]

16. The Resident met with Jim Dostal, Regional Ombudsman, on April 22, 2013 to discuss concerns regarding the Facility's plans to transfer him to another room. The Resident stated that he would make it "miserable" for staff and any roommate to which he was assigned if the room transfer was accomplished.[19]

17. The Resident faxed health-related information to the Vinland National Center (Vinland), a substance abuse treatment facility, on April 24, 2013 in an effort to gain admittance to the Vinland treatment program.[20]

18. On April 24, 2013, the Facility's Interdisciplinary Team met to discuss the Resident's discharge goals. The team determined that the Resident was no longer in need of skilled care, and so proceeded to seek orders from the Resident's treating physician, Dr. Mittal, to that effect.[21] Dr. Mittal informed the staff that he had no safety concerns related to the discharge of the Resident to Harbor Lakes.[22]

19. On April 25, 2013, the Facility moved the Resident to a semi-private room in the Facility.[23]

20. Also on April 25, 2013, the Facility issued to the Resident a written Involuntary Discharge Notice ("First Discharge Notice") indicating that the Resident would be discharged from the Facility in 30 days, on May 25, 2013, to Harbor Lights. The First Discharge Notice specified the basis for the Resident's discharge as follows: "Your health has improved sufficiently so that you no longer need the services provided by this Facility." The First Discharge Notice included an incorrect P.O. Box address for filing an appeal and failed to include the name of the Regional Ombudsman, though it did include contact information for the Ombudsman's office.[24]

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[16] Ex. 14.
[17] *Id.*
[18] Test. of V. Love.
[19] Ex. 2.
[20] *Id.*
[21] Ex. 14; Test. of Kristie Johnsrud.
[22] Ex. 2.
[23] Ex. 14.
[24] Ex. 1.

21. On April 26, 2013, Dr. Mittal issued an order, by telephone, indicating that the Resident could be discharged to his "prior living arrangement" in that he "No longer needs Skilled Care."[25]

22. On May 2, 2013, the Resident was under the influence of alcohol and involved in a verbal altercation with another resident, who had to be removed from the room for his safety.[26] Facility staff reported the matter to law enforcement, through which the Resident was removed from the Facility and placed on a 72-hour hold for observation at Methodist Hospital due to his aggressive and violent behavior.[27] The Resident returned to the Facility on May 5, 2013.[28]

23. On May 6, 2013, Dr. Mittal ordered that the Resident's morphine prescription be decreasingly tapered to discontinuation within approximately one week's time.[29] This action was taken in support of the Resident's plan to attend a treatment program upon discharge from the Facility.[30]

24. As a result of the Resident's aggressive and violent behavior evidenced on May 2nd, the Facility decided it wished to discharge the Resident as soon as possible.[31] As a result, on May 6, 2013, the Facility issued to the Resident a written notice rescinding the First Discharge Notice.[32]

25. Further on May 6, 2013, the Facility issued to the Resident another written Involuntary Discharge Notice (Second Discharge Notice) indicating that the Resident would be involuntarily discharged to Harbor Lights on May 8, 2013. The Second Discharge Notice specified two reasons for the involuntary discharge: (1) "Your health has improved sufficiently so that you no longer need the services provided by this Facility;" and (2) "You endanger the safety of individuals in the Facility." The Second Discharge Notice included the same contact information for filing an appeal and for contacting the Ombudsman as was provided in the First Discharge Notice: the P.O. Box address was wrong and the name of the Regional Ombudsman was omitted.[33]

26. The Resident, acting through Jim Dostal, Regional Ombudsman, filed an appeal of the Second Discharge Notice on May 7, 2013, alleging the following grounds: "Did not give proper notice. Discharge to homeless shelter."[34]

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[25] Ex. 10.
[26] Ex. 14.
[27] Ex. 15.
[28] Ex. 14.
[29] Ex. G-8.
[30] Test. of L. Miller.
[31] Test. of K. Johnsrud.
[32] Ex. 16.
[33] Ex. 13.
[34] Ex. 20.

27. As part of the filed appeal, the Department issued a Notice of and Order for Hearing in the matter on May 8, 2013.[35] The hearing was scheduled for May 28, 2013 before the Office of Administrative Hearings.

28. The Resident completed a Rule 25 evaluation at Micah House on May 10, 2013.[36]

29. On May 13, 2013, the Facility provided the Resident with a written rescission of the Second Discharge Notice.[37] The Facility copied P. Robertson, appeals staff of the Minnesota Department of Health, on the written rescission notice intending that Ms. Robertson would inform the Resident and other interested parties of the cancellation of the pending appeal hearing.[38]

30. Insisting that it had no legal right to but admitting that it would have been "a courtesy" to inform the Regional Ombudsman of the rescission and resulting cancellation of the pending appeal, the Facility admitted that it had not informed the Regional Ombudsman of the rescission of the Second Discharge Notice.[39]

31. On May 14, 2013, the Facility issued to the Resident another written Involuntary Discharge Notice (Third Discharge Notice) indicating that the Resident would be involuntarily discharged to Harbor Lights that same day: May 14, 2013. The Third Discharge Notice specified as follows:

a. The involuntary discharge was based on the following reason: "Your health has improved sufficiently so that you no longer need the services provided by this Facility";

b. The Resident had a right to appeal the discharge decision, by sending a written appeal notice to the following address:

Minnesota Department of Health – Appeals Coordinator
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone (651) 201-4201[40]

32. The Resident was not discharged on May 14, 2013.[41]

[35] Ex. 21.
[36] Ex. 26.
[37] Ex. 22.
[38] Test. of K. Johnsrud.
[39] *Id.*
[40] Ex. 24.
[41] Test. of K. Johnsrud.

33. The Resident traveled to St. Peter, Minnesota, on May16, 2013 for the purpose of visiting treatment programs, but failed to actually visit the programs.[42]

34. The Resident was forcibly removed from the Facility by law enforcement and delivered to Harbor Lights on May 20, 2013.[43]

34. While at Harbor Lights, the Resident eventually was accepted into the Vinland substance abuse treatment program in June 2013.[44]

35. Upon receipt of a complaint, the Department conducted a survey of the Facility on June 13, 2013.[45] Based in part on Informational Bulletin 94-1,[46] the Department issued a Statement of Deficiencies on or about July 12, 2013 in which it identified that the Facility had failed to meet federal regulatory requirements for participation in the Medicare and Medicaid programs in the following respect:

> F-Tag[47] 203: Failure to comply with 42 C.F.R. § 483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE as follows:
>
> Based on documentation review and interviews, the facility failed to give a 30 day advance notice of discharge, as required, for 1 of 3 residents (R1), reviewed for discharge.[48]

36. Relying upon the U.S. Department of Health & Human Services' Centers for Medicare and & Medicaid Services' (CMS) Scope and Severity Grid, the Department assigned the deficiency tag a seriousness level of "D."[49]

36. The Facility filed a timely appeal of the Statement of Deficiencies.

Based on the submissions of the parties at the IIDR, the contents of the record and the Findings of Fact noted above, the Administrative Law Judge makes the following:

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[42] Test. of. L. Miller; Ex. 26 (5/20/13 entry).
[43] Test. of K. Johnsrud.
[44] Test. of Jim Dostal.
[45] Ex. E.
[46] The Department issued F-Tag 203, alleging that the Facility had violated federal law by failing to provide 30 days' notice of the Resident's involuntary discharge. At the IIDR, the Department argued in essence that the 30 days' notice general rule applies in all cases. In support of this position, the Department submitted Information Bulletin 94-1, which specifies that notices issued in noncompliance with 42 C.F.R. § 483.12(a)(6) will have to "provide a new 30 day notice period" upon reissuance. Given the analysis of applicable law included in this Recommended Decision, the Department is urged to reevaluate the completeness of the statements included in Informational Bulletin 94-1.
[47] Deficiency findings are noted in a Statement of Deficiencies under numbered "tags." Each tag corresponds to a specific regulatory requirement.
[48] Ex. E-2.
[49] Ex. E.

RECOMMENDED DECISION

Because Tag F-203 is supported by the facts, the Commissioner should AFFIRM the citation as to scope and severity.

Dated: February 7, 2014

_s/Tammy L. Pust_____
TAMMY L. PUST
Chief Administrative Law Judge

Reported: Digitally Recorded
No transcript prepared

NOTICE

Under Minn. Stat. § 144A.10, subd. 16(d)(6), this recommended decision is not binding upon the Commissioner of Health. Pursuant to Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the facility, indicating whether or not the Commissioner accepts or rejects the recommended decision of the Administrative law Judge within 10 calendar days of receipt of this recommended decision.

MEMORANDUM

Statutory and Regulatory Background

A regulated facility is subject to remedial action if it is not in "substantial compliance" with one or more regulatory standards.[50] A facility in not in substantial compliance if there is a deficiency that creates at least the "potential for more than minimal harm" to one or more residents,[51] which is evidenced at a rating of "D" or above on the CMS Grid. Upon a finding of a lack of substantial compliance, CMS may require the facility to correct the deficiency pursuant to a correction plan and/or impose other sanctions including decertification with CMS.[52]

The Department is legally bound by the provisions of federal and state law and regulation related to facilities enrolled in the Medicare and Medicaid programs. The State Operations Manual, including its Appendix P, provides guidance to regulated facilities regarding compliance with relevant law and regulations. The Department's authority to conduct surveys for CMS and the IIDR process is created by statute. Thus,

[50] 42 C.F.R. § 488.400.
[51] 42 C.F.R. § 488.301.
[52] 42 C.F.R. §§ 488.402, 488.406, 488.408, 488.412, and 488.440.

the Department's jurisdiction to issue a deficiency citation and the Facility's defenses thereto must be analyzed in light of the Department's statutory authority. [53]

All residents of regulated health care facilities "ha[ve] the right not to be transferred or discharged involuntarily unless certain substantive and due process criteria are met."[54] In recognition of the vulnerability of most residents and the fact that their placement in a regulated facility constitutes, for most, the resident's home and not just a temporary place of residence, the law assumes that an involuntary discharge "of a nursing facility resident must be the last resort"[55] and is to be avoided except under narrowly defined circumstances and only with proper notice and an identified right to contest the decision.

Federal law, at 42 U.S.C. § 1396r(c)(2)(B)(ii) and 42 C.F.R. § 483.12(a)(4), provides that a regulated facility may not transfer or discharge a resident without first notifying the resident[56] of the reason(s) for the discharge, recording the reason(s) in the clinical record and including in the written discharge notice the following required information, in relevant part:

> (i) The reason for transfer or discharge;
>
> (ii) The effective date of transfer or discharge;
>
> (iii) The location to which the resident is transferred or discharged;
>
> (iv) A statement that the resident has the right to appeal the action to the State;
>
> (v) The name, address and telephone number of the State long term care ombudsman;
>
> * * *[57]

[53] See *In the Matter of the Application of Minnegasco*, 565 N.W.2d, 706, 711 (Minn. 1997).
[54] *In the Matter of the Involuntary Discharge or Transfer of J.S. by Hall*, 512 N.W.2d 604, 610 (Minn. Ct. App. 1994).
[55] *Id.,* at 612.
[56] If known, a family member or legal representative must also be notified of the transfer or discharge. 42 C.F.R. § 483.12(a)(4) (i).
[57] 42 C.F.R. § 483.12(a)(6).

As it regulates the content of involuntary discharge notices, so does the law govern the timing within which a regulated facility can seek to involuntarily discharge a resident. As a general rule, federal[58] and state[59] law require a 30 day notice period for an involuntary discharge. However, the preemptive[60] general rule recognizes five itemized exceptions to which the general rule does not apply:

> (i) **Except** as specified in paragraphs (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.
>
> (ii) Notice may be made as soon as practicable before transfer or discharge when—
>
> > (A) the safety of individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section;
> >
> > (B) The health of individuals in the facility would be endangered, under paragraph (a)(2)(iv) of this section;
> >
> > (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(ii)[61] of this section;

[58] 42 C.F.R. 483.12(a)(5)(i) provides as follows: "Except as specified in paragraphs (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged."

[59] Minnesota's Patient Bill of Rights, at Minn. Stat. § 144.621, subd. 29, provides as follows:

> Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments.

[60] To the extent that the federal law has occupied this field of law, federal law preempts any inconsistent application of state law. See *In re Estate of Barg,* 752 N.W.2d 52, 64 (2008); *Martin ex rel Hoff v. City of Rochester*, 642 N.W.2d 1, 11 (2002). To the extent that Minnesota's Patient Bill of Rights does not specifically identify the exceptions to the general rule of 30 days' notice for involuntary discharges, federal law applies and controls the result.

[61] Section (a)(2)(ii) of the section provides as follows: "The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility."

> (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(i) of this section; or
>
> (E) A resident has not resided in the facility for 30 days.[62]

One of the listed exceptions involves situations wherein "[t]he resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(ii)[63] of this section."[64] Involuntary discharges based on this or any of the other specified exceptions do not require a 30 day notice period. Instead, the law requires that notice of these types of involuntary discharges be provided "as soon as practicable **before** transfer or discharge."[65]

In other legal contexts, the phrase "as soon as practicable" has been defined to mean "as soon as both possible and practical, taking into account all of the facts and circumstances in the individual case"[66] or "as soon as is performable or feasible."[67] Although the phrase is not defined in the nursing home regulation statute or regulation, applicable law is not silent on how the phrase should be interpreted in this context. The federal statute requires that "in the case of such exceptions [to the general rule of 30 days' notice], notice must be given as many days **before** the date of the transfer or discharge as is practicable."[68] By requiring notice before the intended discharge date, regulated facilities are able to meet their statutory obligation to "provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility."[69]

Facility's Discharge of the Resident

The Facility issued the First Discharge Notice on April 25, 2013, and provided the Resident with 30 days' notice before the scheduled discharge to Harbor Lights on May 25, 2013. The recorded reason for the discharge was that the Resident's "health has improved sufficiently so that you no longer need the services provided by this Facility."[70] As this is one of the listed exceptions to the general requirement of a 30 day notice period, it is clear that the 30 day notice was not required under applicable law. Nevertheless, because the Facility provided the 30 day notice it was bound to comply

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[62] 42 C.F.R. § 483.12(a)(5).
[63] Section (a)(2)(ii) of the section provides as follows: "The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility."
[64] 42 C.F.R. § 483.12(a)(5)(ii)(C).
[65] 42 C.F.R. § 483.12(a)(5)(ii) (emphasis added).
[66] *Bailey v. Amsted Indus. Inc*., 172 F.3d 1041, 1045 (8th Cir. 1999) (interpreting phrase in the context of 29 C.F.R. § 825.302(b)).
[67] *Cargill, Inc. v. Evanston Ins. Co.,* 642 N.W.2d 80, 86 (Minn. Ct. App. 2002) (interpreting the phrase in the context of claims made insurance policy).
[68] 42 U.S.C. § 1396r(c)(2)(B)(ii) (emphasis added).
[69] 42 U.S.C. § 1396r(c)(2)(C).
[70] Ex. 1.

with it. Had the Facility proceeded to involuntarily discharge the Resident pursuant to the First Discharge Notice, it could not have done so until May 25, 2013.

On May 6, 2013, however, the Facility decided it wished to discharge the Resident as soon as possible because of his aggressive and violent behavior, which had landed him on a 72-hour hold at Methodist Hospital. To do so without having to retain the Resident until May 25, 2013, the Facility rescinded the First Discharge Notice. Upon rescission, the First Discharge Notice was null and void, and the Resident's right to remain at the Facility was reinstated.

The reinstatement was short-lived. On the same day the Facility rescinded the First Discharge Notice, it issued the Second Discharge Notice. In the Second Discharge Notice, the Facility again sought to discharge the Resident to Harbor Lights, but this time it intended to do so within two days: by May 8, 2013.

Federal law does not specifically disallow this action. The Second Discharge Notice recited two grounds for the discharge decision: (1) improvement of the Resident's health such that the Facility's skilled services were no longer required; and (2) endangerment of the safety of other residents. Both of these grounds are specified as exceptions to the general rule requiring 30 days' notice. Under either of these grounds, the Facility had a lawful right to seek discharge "as soon as practicable" and was not required to provide the Resident with 30 days' notice. Considering the Resident's involvement in the May 2nd fight which injured another resident, the Facility's testimony was convincing that two days was the period of time it considered to be "as soon as practicable" given the need to confirm that a bed was available at Harbor Lights.

As was his right, the Resident filed an appeal to the Second Discharge Notice.[71] Under Minnesota law, a facility resident cannot be lawfully discharged during the pendency of an appeal related to that discharge.[72]

Five days after the Resident filed his appeal of the Second Discharge Notice and thereby stayed the discharge proceedings, the Facility rescinded the Second Discharge Notice. The Facility explained that it took this action upon its realization that the

[71] Nothing in the federal law prohibits discharging a resident to a homeless shelter in appropriate circumstances.
[72] Minn. Stat. § 144.135.

Second Discharge Notice contained incorrect contact information for filing an appeal and also omitted the required name of the Ombudsman, errors it intended to correct.[73] As a result of the rescission of the Second Discharge Notice, the Resident again had a right to lawfully remain at the Facility.

The very next day, on May 14, 2013, the Facility issued a Third Discharge Notice which contained corrected contact information for filing an appeal, included the name of the Regional Ombudsman, and was again based on the allowed exception to the general rule of 30 days' notice: improvement of the Resident's health such that the Facility's services were no longer required. The Facility argued that it provided the notice the same day as the intended discharge because it had already confirmed a bed was available at Harbor Lights, and so providing notice the same day as the intended discharge was, in the Facility's view, "as soon as practicable" notice."[74]

There are two problems with this argument, both of them fatal to the Facility's position. First, by providing the Third Discharge Notice on May 14, 2013 and scheduling the intended discharge for that same day, the Facility failed in its obligation to give notice before the intended discharge. The governing law specifically requires that "[i]n the case of such exceptions [to the general rule of 30 days' notice], notice must be given as many days **before** the date of the transfer or discharge as is practicable."[75] Although the general rule of 30 days' notice can be lawfully shortened in the circumstances listed in the five statutory exceptions, there is no provision in the law for contemporaneous notice.[76] Therefore, the Third Discharge Notice was not timely provided to the Resident, and any discharge based on that notice was not in compliance with applicable law.

Second, the Third Discharge Notice indicated that the discharge would take place on May 14, 2013. The day came and went without discharge of the Resident. The Resident was not actually discharged until May 20, 2013, when he was forcibly removed

[73] Perhaps not by intent but arguably in effect, the Facility's actions potentially prevented the Resident from effectively prosecuting his filed appeal. Rather than allow the scheduled appeal hearing to proceed, the Facility decided to start the proceedings over by rescinding the operative discharge notice. It claimed it did so because the notice contained technical errors: a wrong Post Office Box address for the Department's appeal division and omission of the name of the Regional Ombudsman. The submissions at the IIDR clearly established, however, that the Resident knew the name of the Regional Ombudsman and had been working with him for weeks, and also knew how to file an appeal – as established by the fact that he had already done so. As recorded in the clinical notes, the Facility knew these facts as well. This knowledge calls into question whether the Facility rescinded the Second Discharge Notice and issued the Third Discharge Notice to correct the technical errors or to gain the advantage of avoiding the stay resulting from the appeal. Evidence in support of this potential conclusion is found in the fact that when the Facility rescinded the Second Discharge Notice, it notified the Department of that fact so the appeal hearing would be cancelled but chose not to notify the Regional Ombudsman directly, notwithstanding its knowledge of the Regional Ombudsman's involvement in the matter. These facts suggest a pattern of behavior by the Facility which draws into question its good faith in the matter.

[74] Test. of K. Johnsrud.

[75] 42 U.S.C. § 1396r(c)(2)(B)(ii) (emphasis added).

[76] See 42 U.S.C. § 1396r(c)(2)(B)(ii) and 42 U.S.C. § 1396r(c)(2)(A)(i)-(iv). See also *Kindred Nursing Centers W., LLC v. California Health & Human Servs. Agency*, DO44215, 2005 WL 1460714 (Cal. Ct. App. June 22, 2005).

from the Facility. The Facility did not provide the Resident with any notice indicating that he would be discharged on May 20, 2013. The law does not allow a regulated facility to provide notice identifying one date and then rely on that same notice insupport of an involuntary discharge on another date. Therefore, the Facility failed to comply with its legal obligation to give proper notice "as soon as practicable" to the Resident, and thereby failed to maintain substantial compliance with federal law.

T. L. P.